STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

EVALUATION OF NEED FOR AN ICF-MR LEVEL OF CARE AND ELIGIBILITY FOR THE DD WAIVER

1. Check appropriate box below:	DATE
Initial Determination ☐	
Annual Redetermination (Last LOC Date) ☐	
Other (i.e., significant change): ☐	
2. Person:	**3. DMH #:**
4. Service Coordinator Signature	**5. Regional Office** ☐ **Other TCM** ☐

The purpose of this form is to determine and document whether or not the above named person has a need for the level of care provided in an ICF-MR and if so, would he or she require ICF-MR placement if not provided services under Missouri's Home and Community Based Waiver for persons with developmental disabilities.

I. Eligibility for ICF-MR:

A. Diagnostic determination of Mental Retardation or a related condition which would otherwise qualify him/her for placement in an ICF/MR:

1. Diagnoses: Axis I _____ Axis II _____ Axis III _____

2. Document the person has functional limitations in THREE (3) or more of the following areas of life activity or, if a child, has or is likely to have, functional limitations in at least three equivalent, age appropriate major life activities:

☐ Self Care ☐ Capacity for Independent Living

☐ Learning ☐ Receptive and Expressive Language (development and use)

☐ Self Direction ☐ Mobility ☐ Attach any documentation that would describe limitations in other domains not listed on the Vineland. (Children Only)

B. Does this person have a need for a continuous active treatment program, including aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed toward the acquisition of the behaviors necessary to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status?

☐ YES ☐ NO

Indicate by checking below, the limitations this person has which require active treatment:

☐ Medical: Has a medical condition that requires ongoing treatment and support.

☐ Behavior: Engages in behaviors that are aggressive or self injurious and therefore requires support from staff to encourage positive social interactions and to prevent injury to self or others.

☐ Communication: Due to limitations in hearing, speaking, reading and/or writing this person has difficulty expressing or understanding written and spoken communication.

☐ Cognitive abilities: Difficulty in processing and understanding information. The rate at which this person learns may be considered slow and creates difficulty in acquiring complex skills.

☐ Daily living skills: Has difficulty carrying out age appropriate daily routines with regard to personal hygiene, financial management, household chores and/or nutritional needs.

☐ Motor development: Has difficulty moving about independently and safely resulting in problems accessing the community, operating household equipment and/or performing activities of daily living.

☐ Socialization: Does not possess adequate social skills necessary to establish and maintain interpersonal relationships with peers, relatives, co-workers and other community members.

☐ Other (specify): _____

II. Is there a reasonable indication, based on your observation and assessment of this person's physical, mental and environmental condition, that he/she will need placement in an ICF/MR unless provided home and community based services under the waiver? ☐ YES ☐ NO

Summarize the information that supports the above conclusion:

III. List below all assessments and evaluations on which you based the conclusion above. For each entry, document the type of evaluation/assessment and by whom and when it was completed. In addition, for evaluations/assessments which were performed over 30 days prior to this level of care determination, also document the date you reviewed the information and on what basis you believe it is still accurate:

Type of Assessment:	Completed By:	Date Completed:	Date of Review if > 30 days:

ATTACH ADDITIONAL DOCUMENTATION IF NECESSARY

IV. Where is the information maintained?

☐ Case record

☐ Other location (specify) _____

TEAM SUPERVISOR (Regional Office or Other TCM Provider) SIGNATURE (My signature states that appropriate tool was used and assessment entered into CIMOR)	SIGNATURE/TITLE	DATE Date entered into CIMOR:
REGIONAL OFFICE APPROVAL OF DETERMINATION (For other TCM providers)	SIGNATURE/TITLE	DATE